

MDR Tracking Number: M5-05-1598-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-31-05.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 8-27-03 through 1-27-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The office visits, electrical stimulation, ultrasound, gait training, group therapeutic procedures, neuromuscular reeducation, manual therapy technique, DME, therapeutic exercises and chiropractic manipulation from 2-4-04 through 3-10-04 **were found** to be medically necessary. The office visits, electrical stimulation, ultrasound, gait training, group therapeutic procedures, neuromuscular reeducation, manual therapy technique, DME, therapeutic exercises and chiropractic manipulation from 3-16-04 through 9-7-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. **The amount due the requestor for the medical necessity issues is \$753.69.**

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-2-05 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The carrier denied CPT Code 99080-73 on 3-2-04 and 4-20-04 with a V for unnecessary medical treatment with a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of \$30.00.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling \$783.69 from 2-4-04 through 4-20-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 3rd day of April 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

April 8, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1598-01
TWCC #:
Injured Employee:
Requestor: Houston Pain and Recovery – Bose Consulting
Respondent: Target Corporation
MAXIMUS Case #: TW05-0042

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians

or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on _____. The patient reported that while at work she injured her lower back when she slipped and fell. An MRI of the lumbar spine performed on 2/10/03 revealed a 2mm disc bulge at the L5/S1 level. The impression for this patient has included an L5/S1 annular disc bulge. Treatment for this patient's condition has included active and passive modalities consisting of electrical stimulation, ultrasound, therapeutic procedures, neuromuscular reeducation, manual therapy technique, therapeutic exercises, and chiropractic manipulation, medications, and epidural steroid injections.

Requested Services

Office visits, electrical stimulation, ultrasound, gait training, group therapeutic procedures, neuromuscular reeducation, manual therapy technique, DME, therapeutic exercises and chiropractic manipulation from 2/4/04 through 9/7/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Position Statement
2. MRI reports 2/10/03
3. Diagnostic/Treatment reports 7/24/03 and 7/22/03,
4. EMG report 2/19/03
5. Orthopedic reports 5/23/03 – 10/1/03
6. Operative reports 4/24/04
7. Daily SOAP notes 8/27/03 – 9/14/04

Documents Submitted by Respondent:

1. Summary of Carrier's Position 2/23/05
2. IME report 5/22/03

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury on _____. The MAXIMUS chiropractor reviewer indicated that the patient was treated for more than a year beginning from February 2003 through February 2004. The

MAXIMUS chiropractor reviewer explained that the patient was evaluated on 3/10/04 by an orthopedic surgeon who diagnosed her with discogenic pain syndrome and failed response to conservative treatment. The MAXIMUS chiropractor reviewer noted that according to the National Spine Society guidelines for unremitting low back pain, this claimant is in the surgical intervention category of care. The MAXIMUS chiropractor reviewer indicated that patients in this phase of care have documented history of failure to respond to initial and secondary treatment, physical examination findings are consistent with surgically treatable lesion, and positive diagnostic testing. The MAXIMUS chiropractor reviewer explained that further treatment beyond surgery, implantation of a spinal cord stimulator, epidural steroid injections or chronic pain management is not medically necessary according to the National Spine Society guidelines.

Therefore, the MAXIMUS chiropractor reviewer concluded that treatment from 2/4/04 to 3/10/04 was medically necessary treatment for the patient's condition. The MAXIMUS chiropractor reviewer also concluded that treatment after 3/10/04 was not medically necessary for treatment of the patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department